Report on Allegations of Worker's Compensation Fraud

State of Wisconsin
Department of Workforce Development
Worker's Compensation Division

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Background.

Section 102.125 of the Wisconsin Statutes requires insurers to report suspected fraud to the Department on their own initiative and, at the request of the Department, to investigate and report on cases of alleged fraud reported to the Department by the general public.[1] After reviewing the results of an insurer's investigation, the Department refers cases to local district attorneys for prosecution if there is a reasonable basis to believe that the case involves insurance fraud as defined by s. 943.395 of the Statutes.[2] The Department is also required to report to the Legislature and the Governor each year regarding the number of allegations received in the prior year, the number of referrals the Department made for prosecution, and the results of those referrals.

This is the Department's fourth report.[3] In addition to providing the required data, prior reports tried to emphasize some aspect of the program. In 1995, the report focused on the Department's role. In 1996, the focus was on the quality of insurance company reporting to the Department. And, in 1997, the report compared the results of the Wisconsin worker's compensation fraud clearinghouse with the results reported in other states. This report emphasizes suggestions from district attorneys.

Conclusions.

This report provides a 5-year perspective from 1994 to 1998. It also summarizes the suggestions that district attorneys have made to insurers interested in increasing the prosecution rate. Specifically, the Department concludes that:

- The fraud clearinghouse program has been extremely cost effective.
- The public's perception of worker's compensation fraud is exaggerated.
- The documented level of worker's compensation fraud is minimal.
- District attorneys would prosecute more cases if insurers were able to give them more timely, consistent and ongoing help.
- District attorneys have suggested several ways in which insurers could improve the documentation of the alleged fraud.

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[1] Section 102.125, Stats., in Attachment 1
[2] Section 943.395, Stats., in Attachment 1
[3] The Department did not submit a report in 1998.

Discussion of Conclusions.

The fraud clearinghouse program has been extremely cost effective. By design, the Department received no additional staff or funding to implement the program in 1994. From the start, the program's success depended on a few Department staff developing a close working partnership with insurance carriers, employers and prosecutors. The Department conducts no independent investigations and has no role in prosecution.

Instead, the Department serves as a clearinghouse, providing relevant information to employers, insurers, prosecutors and policy makers. Perhaps the most publicized role for the Department is administering the worker's compensation fraud "hotline." However, probably more significant is the informal role that Department staff play in advising insurers about prosecutorial problems and educating prosecutors to the nuances of the Wisconsin's worker's compensation system.

The Department has also developed a speaker's program to explain directly to employers what they can do to combat fraud and abusive claims. In the last 3 years, the Department estimates this program has been presented to about 2,000 private-sector risk managers. Typically, the Department speaks to an audience of about 100 personnel staff employed by firms in a particular region of the state. The Department has also used the State's Educational Telecommunications Network (ETN) at least once a year to reach audiences statewide.

It is difficult to make interstate comparisons of fraud and the cost-effectiveness of different state programs to combat it. In attempting that comparison, the Department's 1997 report concluded that Wisconsin does not rank high in factors that promote fraud—generous triggers for coverage, weak evidence requirements, generous benefits relative to wages, and a large worker's compensation bar. The result is that compared to other states[4] allegations of fraud per 1,000 workers seem low in Wisconsin.

Despite the relatively small number of fraud allegations, the 1997 report concluded that when measured against the number of allegations, the fraud prosecution rate in Wisconsin was comparable to these states—all of which had specially funded fraud units. However, at the time of the 1997 report many cases were pending and the conviction rate was lower.

Now, many of the cases that were pending in 1997 have resulted in convictions. The conviction rate seems equally impressive. (See detail in Table 2 in the discussion below.) The point in mentioning those results here is that the results available in 1999 only reinforce the conclusion from the 1997 report that Wisconsin's relatively small program is very effective, even compared to other states spending considerably more on their respective programs.

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[4] For the 1997 report Wisconsin surveyed the following states with Insurance Fraud Bureaus: Louisiana, Massachusetts, Michigan, Missouri and Minnesota.

The public perception of worker's compensation fraud is exaggerated. There have been three significant areas of confusion since the Department set up the fraud clearinghouse in 1994.

First, it is clear that most anonymous callers to the Department's fraud hotline confuse worker's compensation with other private insurance benefits or other public assistance programs such as welfare, unemployment insurance, social security disability or vocational rehabilitation training. In these cases, the person who is allegedly engaged in worker's compensation fraud has never filed a claim for worker's compensation benefits. This is, by far, the biggest problem with anonymous calls to the hotline.

Second, anonymous callers often assume—incorrectly—that an injured worker who has returned to work at his or her former salary is not eligible to receive any further worker's compensation benefits. They do not understand that a full-time employee who has returned to work part-time is typically eligible for temporary partial disability benefits. Likewise, at the end of the healing period, even when the employee has returned to work full-time, he or she may be eligible to receive permanent partial disability benefits. These payments are intended to compensate the employee for the estimated loss of future earning capacity due to a permanent medical condition that is, *in theory*, at least partially disabling. The employee does not have to experience an actual wage loss to receive permanent partial disability benefits.

Third, particularly in the early years of the fraud clearinghouse, insurers significantly underestimated the difficulty of investigating and documenting fraud. Today, insurers have a better understanding of what district attorneys require to initiate prosecution.

Table 1
Alleged Fraud Reported to the Worker's Compensation Division
1994-1998

Year	1994	1995	1996	1997	1998	Total	Average
Fraud Allegations	95	143	152	146	109	645	129
Anonymous Source	84	88	89	107	90	458	92
Identified Source	11	55	63	39	19	187	37
Percent Anonymous	88%	62%	59%	73%	83%	-	71%
Percent Identified	12%	38%	41%	27%	17%	-	29%

Table 1 shows that each year from 1994 to 1998, the Department received an average of 129 fraud allegations. Almost all of the "identified sources" in Table 1 were insurers. Insurers were more active in alleging fraud in the early years of the program in1995 and 1996. Table 1 shows a significant decline in allegations by identified sources (insurers) in 1997 and 1998, as they have become more familiar with the legal standards that must be met.

All of the "anonymous sources" in Table 1 were calls to the Department's hotline. The Department averaged 92 anonymous calls per year, with little year-to-year fluctuation. Since 1995, only one of these anonymous tips has resulted in a recommendation by an insurance carrier to prosecute. 1998 was a typical year for anonymous calls. For 65 of the 90 anonymous calls to the hotline, the Department and the insurers had no record of anyone filing a claim for worker's compensation benefits. The Department directed insurers to investigate the other 25 anonymous tips. Insurers have completed 7 investigations with none recommended for prosecution.

The documented level of worker's compensation fraud in Wisconsin is minimal. Table 2 shows the outcome for the 73 cases that the Department referred to district attorneys for possible fraud prosecution from 1994 to 1998.

Table 2
Worker's Compensation Fraud
Outcome of Alleged Fraud Cases Referred to District Attorneys
1994-1998[5]

Year	1994	1995	1996	1997	1998	Total
Cases Department Referred	5	16	11	28	13	73
Action by District Attorneys						
Currently under review	0	0	0	2	8	10
Refused to prosecute	3	14	8	22	2	49
Initiated prosecution	2	2	3	4	3	14
Results of Prosecution						
Obtained conviction	2	2	2	3	3	12
Prosecution ongoing	0	0	1	1	0	2

District attorneys initiated prosecution in 14 cases, with 12 convictions and 2 ongoing prosecutions. District attorneys refused to prosecute in 49 cases and have 10 cases under evaluation. To date, they have either refused or pursued prosecution in 63 of the 73 cases that the Department has referred to them. To date, 78% (49 of 63) were refused; 22% (14 of 63) were prosecuted.

The 22% overall prosecution rate did not fluctuate much from 1995 to 1997. In 1998, it jumped to 60% (3 of 5). It is not clear whether the preliminary 60% prosecution rate in 1998 is due to the large number of cases still being evaluated (8 of 13) or is a result of what the Department staff perceive as better documentation by insurers who investigated the claims.

[5] In reviewing the data in Table 1, note that the year the Department referred the case is probably not the same year in which the alleged injury or fraud occurred. Insurers are required to report all cases in which there is a reasonable likelihood of fraud, but they are not required to do so until, in the opinion of the insurer, reporting the fraud will not impede its ability to defend against the claim.

When insurers recommend prosecution, the Department must decide if there is a "reasonable basis to believe" that fraud has occurred before recommending prosecution to the local district attorney. Typically, the Department makes a referral if the insurer strongly recommends it. There are two things to remember about the Department's application of this "reasonable-basis-to-believe" standard.

First, if the Department does not refer the case to the district attorney, there is nothing to prevent an insurer that disagrees with the Department's decision from going directly to the local district attorney to seek prosecution. The Department does not keep formal records on this, but anecdotal comments by district attorneys and insurers suggest that it happened a few times in 1994 and 1995. However, each time, the Department was informed that the district attorney declined to prosecute.

Second, if the Department does refer the case for prosecution, the local district attorney may still decline to prosecute based on his or her conclusion that fraud cannot be proved at the higher criminal standard—"beyond a reasonable doubt." The Department's threshold for referral (a "reasonable basis to believe" that fraud occurred) is simply not as stringent as the criminal law standard that the district attorney must apply.

Still, whether one looks at referrals or prosecutions, an annual average of 15 referrals and 3 prosecutions is extremely small in the overall scale of Wisconsin's worker's compensation system. Each year, there are approximately:

- ***65,000 Lost-time injuries***. By law, insurers are required to report to the Department all serious injuries and all cases in which there is a reasonable likelihood of fraud. Insurers report approximately 65,000 serious injuries, but only 15 fraud allegations.

- ***7,000 Disputed claims***. Approximately 7,000 employees request a formal administrative hearing to obtain benefits which insurers have denied. Typically, insurers deny benefits because the insurer's medical examiner disagrees with the employee's treating doctor regarding the nature, cause and extent of the employee's disability. Fraud is rarely an issue in these disputes.

- ***700 Insurance companies and self-insured employers***. There are about 450 insurers licensed to write worker's compensation insurance in Wisconsin and about 250 larger employers and political subdivisions authorized to self-insure. By law, they are required to report worker's compensation fraud to the Department. In the 5-year history of the fraud-reporting program, about 90-percent of these insurers and self-insured employers have not reported a single case.

- ***A billion dollars in benefits paid***. The total amount disputed in all 73 cases of alleged fraud is just under $1 million—or an annual average of less than $200,000.

District attorneys would prosecute more cases if insurers were able to give them more timely, consistent and ongoing help. In the 14 cases in which district attorneys have initiated prosecution they have obtained a conviction in 12. Typically, there is a plea bargain that includes restitution. Two prosecutions are ongoing.

In 1994 and 1995, the quality of the insurance company investigations was poor. By 1996, the quality of the insurers' investigations had significantly improved. However, despite better documentation, district attorneys still usually refuse to prosecute. District attorneys indicate that one consistent problem is that insurers do not provide adequate support once the file has been submitted to the district attorneys office. Insurers need to provide the district attorneys with more consistent, timely ongoing assistance if they want to significantly increase the prosecution rate for insurance fraud.

Worker's compensation is an extremely technical area. Few district attorneys have formal legal training in the obscure legal principles, the state-of-the-art medical issues or the arcane insurance jargon. The abbreviations and acronyms used by experienced claims adjusters, worker's compensation attorneys and doctors are confusing. Some evidentiary documents read like a foreign language. District attorneys need insurers to provide competent, timely answers to their questions. In fact, most district attorneys insist that the insurer assign an investigator who is familiar with the facts of the case to work closely with them to develop the case for prosecution.

District attorneys have suggested several ways in which insurers could improve the documentation of the alleged fraud. Most district attorneys lack the resources to investigate insurance fraud. To successfully prosecute a case of alleged insurance fraud requires proof beyond a reasonable doubt regarding the identity of the person involved in the fraud, the nature of the false representation, and that the insurer made payments based on the false representation. The insurer must also document where the fraud occurred to determine the proper venue for prosecution. District attorneys who are now familiar with the program recommend that an insurer's report should provide at least the following information.

- ***Proof of identity***. Who claimed benefits? When? Where? To whom did the employee speak regarding the injury and his or her ability to work? Always include specific information about the date, time and place where events took place.

- ***Amount paid on the claim.*** The insurer must offer proof that the employee who is named in the complaint received payments. The insurer should provide copies of checks and printouts of payments for both indemnity and medical expenses.

- ***Facts relied on to show falsity.*** The insurer should provide copies of all written reports, recorded statements and successful or unsuccessful attempts to interview witnesses. Include names, addresses and phone numbers of all witnesses. Identify anyone with knowledge that the injury claim is false, for example, someone that saw an accident involving the employee off the work premises.

- ***Medical reports.*** Include medical reports that support your position that the employee was not disabled or not entitled to benefits claimed. However, it is unlikely that an independent medical report, standing alone, will be adequate to prove that the employee has committed fraud. Include statements from all interviews of medical practitioners regarding the medical condition of the employee

- ***Video tapes.*** Only use surveillance tapes taken during the time that benefits were paid. Tapes that show employees doing various activities beyond the limitations described in their medical reports do not provide conclusive evidence that the employees are committing fraud. People have "good days" and "bad days." Video that shows a person at work when the person has claimed that he or she is totally disabled is generally more helpful.

- ***Interview the employee.*** In all cases the insurer should interview the accused person about the allegations of fraud.

- ***Develop a synopsis.*** Summarize the information in a manner that relates the documentation in the file to the elements that must be proved in s. 943.395, Wis. Stats.

Attachment 1

102.125 Fraudulent claims reporting and investigation. **(1)** If an insurer or self-insured employer has evidence that a claim is false or fraudulent in violation of s. 943.395 and if the insurer or self-insured employer is satisfied that reporting the claim to the department will not impede its ability to defend the claim, the insurer or self-insured employer shall report the claim to the department. The department may require an insurer or self-insured employer to investigate an allegedly false or fraudulent claim and may provide the insurer or self-insured employer with any records of the department relating to that claim. An insurer or self-insured employer that investigates a claim under this subsection shall report on the results of that investigation to the department. If based on the investigation the department has a reasonable basis to believe that a violation of s. 943.395 has occurred, the department shall refer the results of the investigation to the district attorney of the county in which the alleged violation occurred for prosecution.

(2) Annually, the department shall submit a report to the appropriate standing committees under s. 13.172

(3) and the governor detailing, for the previous year, the number of reports under sub. (1) that the department received, the number of referrals for prosecution that the department made and the results of those referrals.

943.395 Fraudulent insurance and employee benefit program claims. **(1)** Whoever, knowing it to be false or fraudulent, does any of the following may be penalized as provided in sub. (2):

(a) Presents or causes to be presented a false or fraudulent claim, or any proof in support of such claim, to be paid under any contract or certificate of insurance; or
b) Prepares, makes or subscribes to a false or fraudulent account, certificate, affidavit, proof of loss or other document or writing, with knowledge that the same may be presented or used in support of a claim for payment under a policy of insurance.
(c) Presents or causes to be presented a false or fraudulent claim or benefit application, or any false or fraudulent proof in support of such a claim or benefit application, or false or fraudulent information which would affect a future claim or benefit application, to be paid under any employee benefit program created by ch. 40.
(d) Makes any misrepresentation in or with reference to any application for membership or documentary or other proof for the purpose of obtaining membership in or noninsurance benefit from any fraternal subject to chs. 600 to 646, for himself or herself or any other person.

(2) Whoever violates this section:

(a) Is guilty of a Class A misdemeanor if the value of the claim or benefit does not exceed $1,000.
(b) Is guilty of a Class E felony if the value of the claim or benefit exceeds $1,000.